



REGIONAL APPEAL 2021 - 2023

COVID19 CRISIS

in the MIDDLE EAST (Iraq, Jordan, Lebanon, Libya, Syria, oPT and Yemen) and the SOUTH CAUCASUS (Georgia, Armenia & Azerbaijan)

**DECEMBER
2020**



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1. NEEDS AND CHALLENGES

COVID19 IS HAVING AN IMMEDIATE AND CONSIDERABLE IMPACT ON HUNGER AND FOOD SECURITY

Action Against Hunger has been operational in the Middle East and the South Caucasus for many years and provides support to vulnerable people in the Occupied Palestinian Territory, Jordan, Iraq, Lebanon, Syria, Yemen, Turkey, Georgia (including the breakaway region of Abkhazia), Armenia and Azerbaijan and is currently starting to work in Libya. COVID19 has presented a set of unique challenges and issues for humanitarian actors - including our own organization - working in these countries.

COVID19 is having a significant impact on countries and health systems across the Middle East and South Caucasus. Countries that, in many cases, were already facing significant insecurity, population displacement and economic challenges are now having to cope with a pandemic that they don't have the resources to respond to. For vulnerable communities and populations across the region, the pandemic is further undermining their livelihoods and access to basic services. While many countries, such as Iraq, Lebanon, Jordan and oPT, responded to the first wave of COVID19 through enforcing tough lockdown measures; when these measures were ended infection rates increased and these countries are now seeing widespread community transmission and their health systems are gradually being overwhelmed. In addition, the tough lockdown measures that were previously used to control the infection rate, are no longer seen as politically and economically viable and so governments are increasingly limited in how they can respond.

Since August there has been a steady increase in the rate of transmission of COVID19 in most countries in the region, and - as a result - the effects of the pandemic continue to have a huge impact on public health and economies in the Middle East.

OVER A 3-YEAR PERIOD WE EXPECT TO SEE A HIGHER DEPENDENCY ON EXTERNAL SUPPORT, A SLOWER PACE OF DEVELOPMENT AND AN EXTENDED EMERGENCY.

Access constraints have always existed with regards to our work in the Middle East and the South Caucasus. Whether that has been caused by conflict (in Georgia, Yemen, Libya, Syria and Iraq; for example) and / or administrative constraints (such as in oPT), Action Against Hunger has always had to work its way through complex access issues to effectively reach beneficiaries in the Middle East and South Caucasus and knows how to navigate across this type of barriers.

The oPt **CONTEXT** is constrained by three different levels of C-19 restrictive measures. In the West Bank, the Palestinian Authority (PA) has put in place a new set of regulations following a traffic light coloured scheme (red, yellow or green) to each governorate, according to the rate of infection and positive cases, leading thus to an appropriate set of regulations. The Gaza Authorities have adopted the same kind of monitoring and restrictive system. As for the annexed East Jerusalem, population is abiding to the regulations from the Government of Israel.

Unfortunately, issues around access have become more complicated since the start of the COVID19 pandemic, at a time when greater access is required. Our programmes have been quickly and positively adapting to this situation and Action Against Hunger has developed new methodologies to continue to deliver its activities in the changing context. For example, in Iraq Action Against Hunger has developed remote protocols to continue its Mental Health and Psychosocial Support (MHPSS) programme to ensure that vulnerable people are still reached with psychosocial

support. In Lebanon, we have also developed new features to allow for digital monitoring tools to step up adapted controls during Water Trucking and Desludging activities.

The **viability and reliability of data** collected on COVID19 is problematic due to political – but also practical (lack of reliable testing; lack of health facilities) reasons in many parts of the Middle East and the South Caucasus and therefore the number of cases that are officially reported often just represent the tip of the iceberg of a much more concerning situation.



| COUNTRY | NO OF CASES | NO OF DEAD | TREND |
|------------|-------------|------------|---|
| Lebanon | 127,903 | 1,018 | Increasing Caseload, worsening since August |
| Jordan | 219,430 | 2,751 | Increasing Caseload |
| OPT | 98,850 | 822 | Increasing Caseload |
| Israel | 332,192 | 2,831 | After a rapid increase, now under control |
| Yemen | 2,081 | 606 | Stable Caseload |
| Syria | 7,887 | 417 | Increasing Caseload |
| Turkey | 494,351 | 13,558 | Increasing Caseload |
| Libya | 82,809 | 1,183 | Increasing Caseload |
| Iraq | 552,549 | 12,258 | Increasing Caseload |
| Georgia | 135,584 | 1,267 | Increasing Caseload |
| Azerbaijan | 118,195 | 1,361 | Increasing Caseload |
| Armenia | 135,124 | 2,164 | Increasing Caseload |

* COVID19 in the Middle East & South Caucasus – 01 December 20 11:17 GMT (source <https://covid19.who.int/>)

JORDAN now has one of the highest daily per capita COVID19 rates in the world. More than 400 cases have been confirmed in Azraq Camp in October 2020, where overcrowding, lack of access to hygiene and cleaning supplies, and communal WaSH facilities in constant need of repair increase transmission risks.

With the exception of Jordan (which, uniquely in the region, is a producer and exporter of PPE), the lack of Personal Protective Equipment (PPE) is a common feature in the most war-ravaged countries of the Middle East and also in the South Caucasus. Where governments have had neither the money nor the influence to secure significant quantities of PPE; NGOs, such as Action Against Hunger, have worked to ensure that appropriate PPE is available where most needed. Action Against Hunger has used its presence and experience to procure and pre-position PPE stocks in a number of countries to ensure that essential, life-saving activities can continue in a COVID secure way. The market for PPE has effectively been overwhelmed; and securing equipment to ship into the countries has been proving to be highly problematic. The market constraint is often coupled by ongoing high devaluation of the currencies, high prices, inflation and economic recession.

Lockdown has also meant that Action Against Hunger had to engage its teams in alternative manners, as some international staff couldn't travel in and/or out of the countries and all **staff** – local and international – **needed to adapt to movement constraints** within the territory and to adjust personal and professional management according to this new situation.



- The **IMPACT OF COVID19 ON PUBLIC HEALTH** across the region is growing and, without additional support, many countries will not be able to cope. The pressure placed on already fragile Health systems by COVID19 in some of the countries that we work in has meant that routine primary health or maternal health consultations supported by Action Against Hunger have not been completed in the same quantity as during a normal period. In addition to the short-term impact, the mid and longer-term impact will likely see increased challenges and there will be growing pressure on Action Against Hunger to provide more services to a higher number of affected people.

In **YEMEN**, after five years of war, the health system is collapsing with only half of health facilities fully functional and close to 18 million people lacking access to adequate healthcare. Health facilities that remain functional operate with reduced capacity, due to a lack of salaries for health personnel and difficulties to import medicines and medical supplies. Most health facilities in the country struggle to provide continuous life-saving nutrition and health services and, without additional support and resources, will become overwhelmed.

- The **IMPACT OF ACCESS TO WATER AND GOOD SANITATION DURING COVID19** is significant and this raises huge challenges in many countries in the region, particularly those managing large displaced communities. For example, in refugee camps in Jordan much of the water and sanitation infrastructure is communal, and as cases of COVID19 have risen in these camps, the com-

munal nature of these facilities has led to an increasing risk of transmission for an already extremely vulnerable population. In informal camps, and among households and communities returning to their homes following insecurity and violence, these risks, while less visible, are also present.

Most people are now aware, hygiene – and in particular handwashing – is a key component of controlling the spread of the virus. Yet the Middle East is the most water scarce region in the world and thus it has been difficult to secure permission to pump more water to enable, for example, more water trucking to take place to vulnerable refugee and IDP communities in war affected and refugee hosting countries. In the South Caucasus, outside of the major cities, village water supplies are often in poor condition and many schools, IDP collective centres and health points suffer from degraded water/sanitation facilities.

Without additional resources to address these challenges, vulnerable people will be put at further risk.

- The **SOCIO-ECONOMIC IMPACT of the COVID19** crisis has yet to be fully felt; but already signs of what is to come are showing through with extremely high rates of unemployment being reported in some countries whose economies have been shut down for the last few months. In Jordan, for example, a country heavily reliant on the tourist sector; the effectiveness of their lock down has completely killed their massive tourism sector leading to an estimated 25% unemployment rate. This is unlikely to recover for years to come. Other countries already in difficult economic situations, such as Lebanon, have seen their economies further devastated by the COVID19 crisis, as well as by the explosion in the port of Beirut.

As reported by WFP's assessment in June 2020, 41% **LEBANESE**, reported not having stockpiled food during the lock down due to their inability to afford the costs, with 64% of Syrians reporting the inability to have emergency stocks, mainly due to unaffordability. The need for food was expressed by 70% of elderly and 80% of People with Special Needs (PwSNs) and/or with a critical medical condition.

- There is increasing evidence that **THE ECONOMIC CRISIS IS PUSHING PEOPLE BELOW THE POVERTY LINE** in many countries; affecting their food security (the basic ability to put food on the table for their families) and their livelihoods (the ability to provide a minimum of income to families to be able to provide for the basics in life including water, food, education and health care).

According to the World Bank (MPO Oct 2020), in the **oPT** projections based on GDP per capita growth indicate that the poverty rate is constantly increasing since 2016, being at 24 percent in 2018 and 27.5 percent in 2020, an increase of 5.6 percentage points in the last four years. This amounts to approximately 1.4 million people living in poverty in 2020.

- Many of the countries in the Middle East and the South Caucasus had **LIMITED AMOUNTS OF SOCIAL COHESION** even prior to the crisis – demonstrations and social

unrest have increased across the region as a result of the crisis. They are increasingly sectarian in places like Lebanon and Iraq and even occurring in places like Syria. The increase in poverty will only exacerbate tensions and will lead to **INCREASED INEQUALITY AND EXCLUSION**.

- While most of the Humanitarian Approach in the Region has been focusing on **PROTECTION** to minimize the risks that people face during times of conflict or disasters, COVID19 is now acting as an extra burden that will further exacerbate tensions and will likely act as a factor that will likely fuel **FUTURE EMERGENCIES**.

- Attending the COVID19 response is further highlighting how **FRAGILE THE HEALTH SYSTEMS** are and how they are diverting the already limited resources at the detriment of the chronic disease care and primary health services.

- Poverty will further impact **ACCESS TO HEALTH CARE SERVICES**, especially in urban environments.

- Response should include **PREPAREDNESS ACTIONS** to ensure that each country is able to face future pandemics. The pandemic worldwide has alerted us all on how poorly prepared we are to face these situations. It will be vital to support **CONTINGENCY PLANS REVISION** to consider a multi-risk approach, in health systems and local institutions, coupled with upgraded stocks and procedures for response. Besides, support to **COORDINATION AND COLLABORATION** between health agencies at the regional level, as well as between animal, human and environmental practitioners should be strengthened to create a more responsive environment.

• Furthermore, the region is particularly characterized by **MIGRANTS AND REFUGEES PATTERNS**, as both economic migrants that used to move to the region (for example, migrant workers to Lebanon) or within the region (Palestinian workers employed in Israel) and IDPs and refugees hosted in several countries (Lebanon, Iraq, Jordan, Georgia etc.) will be pushed into more irregular movements abroad, trying to alleviate their exposure to such economic distress.

To help support people both with the short-term impact and longer-term challenges of the COVID19 crisis the **INTERNATIONAL COMMUNITY NEEDS TO INCREASE THEIR SUPPORT** to the vulnerable people of the region. Yet, even before the COVID19 pandemic, International Actors were drawing down their humanitarian and development support to the Middle East and the South Caucasus, and even adopting more restrictive measures such as putting in place (or worsening) the already existing sanctions in the Middle East.

Since mid-March, significant price increases and some shortages of basic goods (on average 40-50 per cent for food staples) and personal protective equipment (face masks, hand sanitizers/ up to 5,000 per cent increase) have been reported across **SYRIA**. Fuel prices (diesel and petrol also increased, with the cost of diesel and petrol in the informal market more than 160 per cent and 248 per cent higher respectively. The exchange rate also further weakened since mid-March to the lowest point on record, closing at an unofficial rate on 25 March of SYP 1,325 to US \$1.



2. OUR RESPONSE AND PRIORITIES

PREVENTION & CONTENTION

MANAGING SECONDARY CONSEQUENCES OF THE COVID-19

COORDINATION & ENGAGEMENT

| WHO PILLAR | PILLAR 2 Risk communication and community engagement | PILLAR 3 Surveillance, rapid response teams and case investigation | PILLAR 6 Infection prevention & control (IPC) | PILLAR 7 COVID-19 Case Management Management | PILLAR 3 Surveillance, rapid response teams, and case investigation | PILLAR 8 Operational support and logistics OperationManagement | PILLAR 1 Coordination and national level & Engaging international and national donors |
|------------------------------|--|---|--|--|---|---|--|
| TPF Axis | Protecting Lives | | | | Protecting Lives | | Protecting Lives |
| TPF Programme / Intervention | Providing Health & nutrition life-saving interventions | | | | Ensuring coverage of basics needs | | Preparedness |
| TPF Modality | Health promotion & sanitation in emergency Contingency and response mechanisms in the community | Surveillance mechanisms/ Monitoring of risks and triggers Integrated Management of Childhood Illness: PCME / IMCI / IMNCI | Contingency and response mechanisms in the community iCCM+NUT IYCF-E Integrated Management of Childhood Illness: PCME / IMCI / IMNCI Health promotion & Sanitation in emergency Water Supply in emergency / Water Supply in Health & NUT centres MISP (Minimum Initial Service Package) Direct and mobile RMNCH service provision Environmental sanitation PCMAS/PCMAM Shielding | MISP (Minimum Initial Service Package)/ Direct and mobile RMNCH service provision Integrated Management of Childhood Illness: PCM / IMCI / Capacity restoration of RMNCH services | Surveillance mechanisms / Monitoring Of risks and triggers | Food Assistance Livelihood protection Canteens Multipurpose Cash Assistance | Multistakeholders coordination for response and planning |
| Activities MAP v2 | <p>2.1. (NUT-H) Conduct rapid behavior assessment to understand key target audience, perceptions concern and rumor tracking.</p> <p>2.2. (NUT-H) Prepare local messages and pre-test through a participatory process, specifically targeting key stakeholders and at-risk groups.</p> <p>2.3. (NUT-H) Identify trusted community groups and local networks.</p> <p>2.4. (NUT-H) Engage with existing public health and community-based networks, mass media campaign producing locally adapted TV, Radio and Facebook adverts.</p> <p>2.5. (WASH) Public health promotion through awareness activities.</p> <p>2.6. (DRM) Support community leaders in applying preventive measures.</p> | <p>3.1. (NUT-H) Actively monitor and report disease trends, impacts, population, perspective to global laboratory / epidemiology systems.</p> <p>3.4. (NUT-H) Training on contact tracing, isolation protocols and COVID SOP.</p> <p>3.5. (NUT-H) Train and equip Rapid Response Teams in Outbreak areas.</p> <p>3.6. (NUT-H) Studies on lessons learned in the beneficiary / community and health structures in relation to the response to the public health problem.</p> | <p>6.1. (NUT-H) Mapping health structures that may be involved in the response.</p> <p>6.2. (NUT-H) Support in the implementation of a monitoring plan in health structures for health personnel exposed to confirmed cases of COVID-19.</p> <p>6.3. (NUT-H) Community treatment of undernutrition iCCM+</p> <p>6.4. (NUT-H) Interventions for the prevention of malnutrition for Pregnant and Lactating Women and children U5Y.</p> <p>6.5. (NUT-H) Training health staff for early detection and COVID management.</p> <p>6.6. (NUT-H) Actions of awareness / information in relation to prevention in camps and among the migrant population.</p> <p>6.7. (NUT-H) Distribution of IPC kits and PPE.</p> <p>6.8. (NUT-H) Develop IPC actions in the community.</p> <p>6.9. (WASH) New water points and handwashing solutions.</p> <p>6.10. (WASH) Safe distribution of hygiene and disinfection kits.</p> <p>6.12. (WASH) Support for the shielding of persons most at risk.</p> <p>6.13. (WASH) Delivery of water supply services .</p> <p>6.14. (WASH) Construction / rehabilitation of sanitation facilities.</p> <p>6.15. (WASH) Sanitation and waste management services.</p> <p>6.16. (WASH) Technical training 7 coaching in WASH.</p> <p>6.17. (NUT-H) CMAM.</p> <p>6.18. (NUT-H) SRH Care.</p> | <p>7.1. (NUT-H) Support in health structures' capacities for case management.</p> <p>7.2. (NUT-H) Support to COVID isolation centers.</p> <p>7.3. (NUT-H) Mental health and Psychosocial support.</p> | <p>3.7. (FSL) Monitor and assess the socioeconomic impacts of the outbreak at household / community levels.</p> <p>3.8. (FSL) Monitor changes in markets.</p> <p>3.9. (FSL) Cash & Vouchers Assistance Preparedness (for preparing the economic recovery phase).</p> | <p>8.1. (FSL) Provision of basic assistance: Food assistance.</p> <p>8.2. (FSL) Provision of basic assistance: livelihood support.</p> <p>8.4. (FSL) Provision of basic assistance: multipurpose CASH.</p> <p>8.6. (FSL) Provision of basic assistance: CANTEENS.</p> | <p>1.1. (DRM) Coordination meetings with UN Clusters on COVID-19 issues (WASH, Health, NUT, FSL, Protection...)</p> <p>1.2. (DRM) Coordinating meetings with Cash Working Groups, including National Social protection actors around COVID-19 issues.</p> <p>1.3. (DRM) Following the funding opportunities of our current donors at country level.</p> <p>1.4. (DRM) Assessing new funding opportunities at country level putting in value our value proposition.</p> <p>1.5. (DRM) Dissemination and communication of our intervention aimed to donors and society.</p> |

DETAILS ON ACTIVITIES (in black are activities with metrics; in color activities without metrics).

The technical programming response of Action Against Hunger caused by the COVID19 fits within the technical axis "Protecting Lives". This response is aligned with the next three programs included in this technical axis:

1. PROVIDING HEALTH & NUTRITION LIFE-SAVING INTERVENTIONS

2. ENSURING COVERAGE OF BASICS NEEDS

3. PREPAREDNESS

The technical programming response contributes to our two impact strategic goals, and

puts special emphasis on the stakeholders' strategic goals:

- Respond to stakeholders' needs on time and with high quality
- Achieve and stronger and engaging organizational positioning

The aim of our technical programming response to COVID19 is to contribute to reduce the number of people infected by COVID19 and to relieve the socio-economic effects on the population through the next three components:

| CONTAINMENT & PREVENTION | MANAGING SECONDARY CONSEQUENCES OF THE COVID19 | COORDINATION AT NATIONAL LEVEL & ENGAGING INTERNATIONAL AND NATIONAL DONORS |
|---|---|---|
| Community engagement Strengthen the capacities of the health system and the community in responding to the problem | Monitor the socioeconomic impacts of the pandemic Provide basic assistance to the most vulnerable population | Achieve a stronger and engaging organizational positioning |

The response of Action Against Hunger is aligned with the recommendations of WHO following the next pillars. Pillar 1: Country-level coordination, planning, and monitoring; Pillar 2: Risk communication and community engagement; Pillar 3: Surveillance, rapid response teams, and case investigation; Pillar 4: Points of entry; Pillar 5: National laboratories; Pillar 6: Infection prevention and control Preparation of risk plans and training for their implementation (health centre structures and community); Pillar

7: Case management; Pillar 8: Operational support and logistics.

During the first months of pandemic, we witnessed how the situation led to an increase of pre-existing injustices and higher affectation to marginalized groups, as the current situation gives higher chances to local authorities to control people's movement and instigate further disparity. While the general public's attention and priorities focus on COVID19, **exposure to abuses is higher** and

perpetrators find easier ground to act (Gender Based Violence, land grabbing, unequal distribution of services, violence patterns on minors ...). We also detect men feeling more delegitimized under COVID19.

Furthermore, we have noticed a **change in the nutrition patterns** - due to the decrease of income - and the early introduction of complementary food instead of breastmilk has been reported, coupled with biased knowledge that leads families to introduce milk or diluted formula (expensive). Therefore, we expect an increase in the number of undernourished people under the first year of life and an increase in chronic malnutrition and obesity.

There is a widespread **lack of transparency of health service management**; non equitable access to services; human and financial resources being redirected to respond to the pandemic, thus creating gaps in the already fragile health system; active screening has stopped and there is no possibility to conduct /anthropometric measurements (weight and height) as we need to avoid close contact; health systems are unlikely to be able to upgrade their preparedness in the coming years.

We have identified that there are now **new vulnerable groups** arising from the COVID crisis, such as the elderly population, small and medium business owners and those employed within the tourism and hospitality sector, while those who were already unemployed face even more acute difficulties in securing a job.

The work of Action Against Hunger until today has focused on:

1. Supporting the diffusion of prevention and hygiene related messages and items through relevant means and in accordance with the national guidance

2. Increasing access to water, sanitation, and disinfection materials in key areas and institutions (quarantine centres, health institutions and schools, collective centres and communities with limited services) to improve prevention, response and resumption of activities

3. Supporting vulnerable households, communities and businesses affected by the suspension of economic life and/or loss of family member or the breadwinner during or after the pandemic to cover basic needs and restore livelihoods

4. Advocating towards the relevant authorities for the rights of everyone -including the most vulnerable - to have access to basic services and in particular safe, sufficient and affordable water and health services

5. Moreover, Action Against Hunger is piloting the shielding approach in Informal Tented Settlements, which consists of increasing the community capacity to protect those most at risk from COVID19 through the identification of green zones and a high compliance with IPC measures. Household level support to protect the most vulnerable, is also being explored for households who during the community sessions on isolation have raised concerns and requested support from Action Against Hunger.

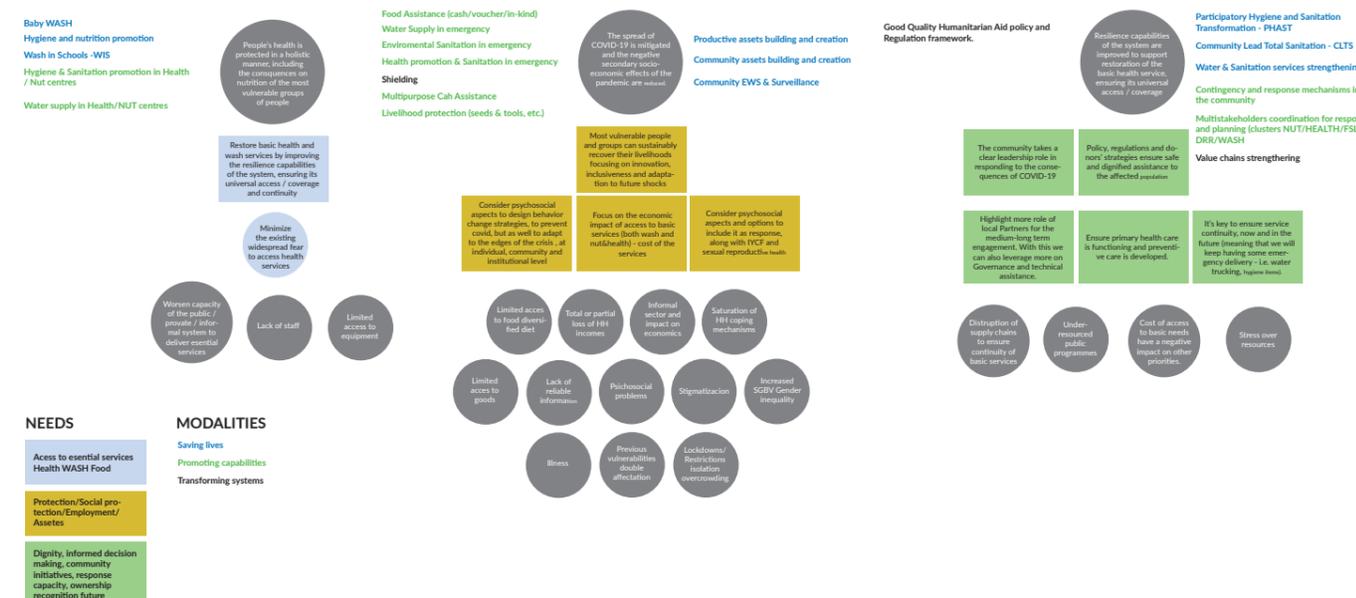
DRIVERS TO CHANGE THE SITUATION

- Focus on the economic impact of access to basic services (both WASH and Nutrition and Health) – cost of the services and access to food.
- It's key to ensure service continuity, now, and in the future (meaning that we will keep having some emergency delivery – i.e. water trucking, hygiene items...) and guarantee social protection systems.
- Minimize the existing widespread fear to access health services.

- Highlight more the role of local Partners for medium and long-term engagement. With this we can also leverage more on Governance and technical assistance.
- Consider psychosocial aspects of the pandemic and to include options as part of the response, along with IYCF and sexual reproductive health
- Ensure primary health care and community is functioning and preventive care and curative is developed.
- Understand the social dynamics, identify barriers to leverage on the Behaviour Change approach at the individual, community and institution level, to boost local leadership to support local initiatives to face the crisis.



OUR CAUSE-EFFECT ANALYSIS



OUR CHANGE OBJECTIVES

With a longer-term approach to our COVID19 response programming, the diagram above shows the bottom-up approach that we used in order to build upon the Objectives of Change that we will pursue.

We start from the bottom **black circles** that summarize the **situation** that we observed in the field; in the **coloured circles** we define the **needs** towards which we can take action; we group them according to the 4 **Outcomes** we will measure; we state in the **grey circles** the 3 main Change Objectives we want to promote.

Each Change Objective will be supported by different **modalities of intervention**, as per the main AAH Technical axis: Saving Lives, Promoting Capabilities and Transforming Systems.

In Action Against Hunger we believe that we must respond to this crisis as quickly as possible and take advantage of the situation to work on the structural improvement of systems at the regional level, particularly those related to food production and health.

Our **main objective** is that by the end of 2023 people whose level of exclusion has sharpened because of COVID19 (such as women, refugees, youth and minors, informal workers etc.) in the areas in

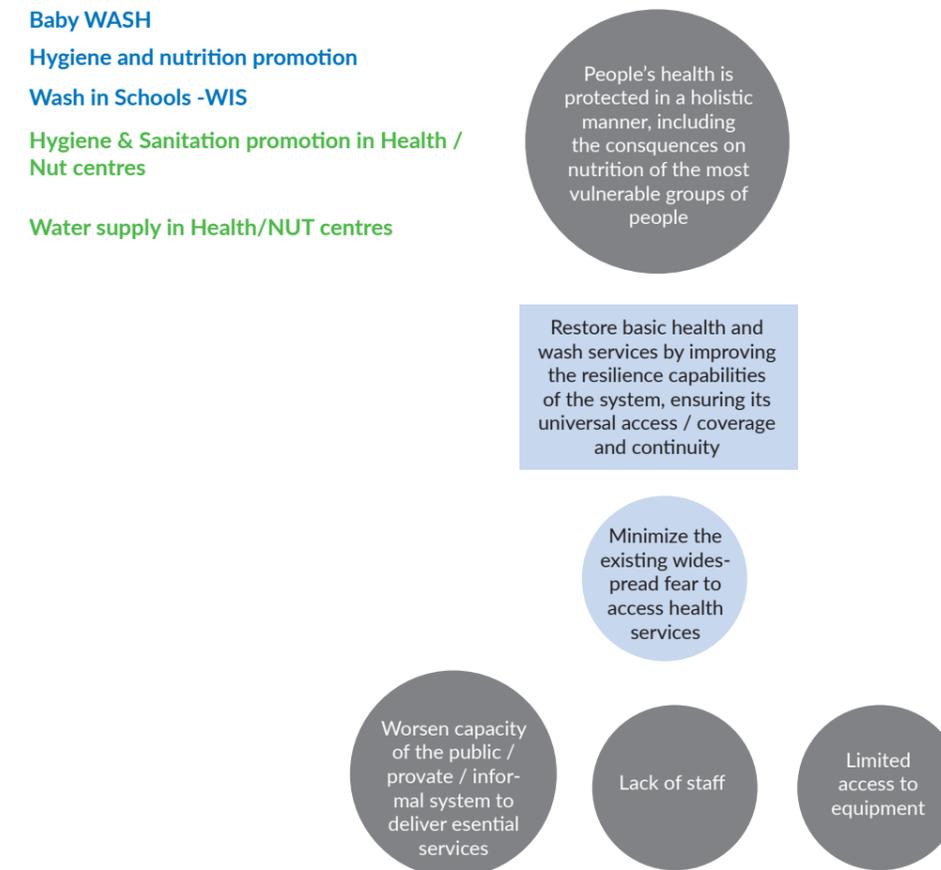
which we work, have the capacity to satisfy their nutritional needs and are able to access essential services, food and goods as they have been resilient to the impact of COVID19 and have improved livelihood opportunities, local production systems and social protection structures.

To achieve this, we will:

1. MITIGATE THE SPREAD OF COVID19 AND REDUCE THE NEGATIVE SECONDARY SOCIO-ECONOMIC EFFECTS OF THE PANDEMIC



2. PROTECT PEOPLE'S HEALTH IN A HOLISTIC MANNER, INCLUDING THE CONSEQUENCES ON NUTRITION OF THE MOST VULNERABLE GROUPS



3. IMPROVE RESILIENCE CAPABILITIES THROUGH THE RESTORATION OF BASIC HEALTH SERVICES, ENSURING ITS UNIVERSAL ACCESS AND COVERAGE

Good Quality Humanitarian Aid policy and Regulation framework.

Resilience capabilities of the system are improved to support restoration of the basic health service, ensuring its universal access / coverage

Participatory Hygiene and Sanitation Transformation - PHAST

Community Lead Total Sanitation - CLTS

Water & Sanitation services strengthening

Contingency and response mechanisms in the community

Multistakeholders coordination for response and planning (clusters NUT/HEALTH/FSL/DRR/WASH)

Value chains strengthening

The community takes a clear leadership role in responding to the consequences of COVID-19

Policy, regulations and donors' strategies ensure safe and dignified assistance to the affected population

Highlight more role of local Partners for the medium-long term engagement. With this we can also leverage more on Governance and technical assistance.

Ensure primary health care is functioning and preventive care is developed.

It's key to ensure service continuity, now and in the future (meaning that we will keep having some emergency delivery - i.e. water trucking, hygiene items).

Disruption of supply chains to ensure continuity of basic services

Under-resourced public programmes

Cost of access to basic needs have a negative impact on other priorities.

Stress over resources



3. HOW WILL WE DO IT

OUR VISION

For a world free from hunger.
For a world in which children and adults have access to sufficient nutritious food and clean water and are able to attain these with dignity. No child should ever die from hunger and severe undernutrition should be eradicated

THE CHANGE WE WANT TO SEE

The spread of COVID-19 is mitigated and the negative secondary socio-economic effects of the pandemic are reduced

People's health is protected in a holistic manner, including the consequences on nutrition of the most vulnerable groups of people

Resilience capabilities of the system are improved to support restoration of the basic health services, ensuring its universal access / coverage

The Outcomes we aim to achieve

1. Building resilience in terms of HR, leadership capacity and consumables/drugs supply
2. Authorities receive technical support for increasing their capacities to cope with management and delivery of the basic services
3. Health facilities receive support (equipment, water availability...)
4. The system strives for reducing the inequities of services provision
5. Supply chains are maintained and timely replenished
6. Basic services are properly running
7. Basic needs assistance is provided through cash assistance ensuring safety and dignity
8. Targeted vulnerable groups receive the service they need in a individualized and continuative manner
9. Behaviours change approach strengthened for an increased collective awareness towards the impact of the disease
10. Feeding and nutritional practices are promoted among the targeted groups
11. Care practices and psychosocial support is offered to leverage on the well-being of the targeted groups
12. Capacities of veterinary and health services are strengthened for one-health approaches (South Caucasus only)

Restore basic health and wash services by improving the resilience capabilities of the system, ensuring its universal access / coverage

The community takes a clear leadership role in responding to the consequences of COVID-19

1. People, households and communities vulnerable to COVID-19 are supported
2. Community structures activated to support the provision of basic services
3. Spaces created for dialogue to take place between the different actors of change

Most vulnerable people and groups can sustainably recover their livelihoods focusing on innovation, inclusiveness and adaptation to future shocks

1. Data and information related to households' economy and market are consolidated for guiding long-term economic recovery
2. Local and sustainable agricultural systems are promoted to improve food supply and competitiveness of small-scale farmers
3. Key sectors and value chains that can contribute to consolidate the local economy and create jobs are strengthened
4. Well targeted and designed social safety nets are piloted at small-scale
5. Tourism sector to support and reinforce, it's an equitable sector that affects several population groups

Policy, regulations and donors' strategies ensure safe and dignified assistance to the affected population

1. Humanitarian Coordination to address barriers emanating from COVID-19 measures and contextual humanitarian access security challenges
2. Donor governments support and advocate for an adequate humanitarian response to the impact of COVID-19
3. We analysed the impact of COVID-19 on returnees
4. We detect potential loss of rights of women and promote and advocate for gender analysis approach across the interventions of the humanitarian actors

The steps we will take to deliver those outcomes

1. Accompany the coordination mechanisms in the development of nutritional surveys and assessments in each country. Supporting digital assessments and surveys.
2. Coordination / participation in Cash & technical Working Groups, support to MEB definition, design and implementation of cash assistance, knowledge building and sharing
3. Continuous support and evaluation of the quality of service and its capacities in relation to the COVID-19 of the first level health structures.
4. Feeding and nutritional practices are promoted among the targeted groups develop actions of IYFC.
5. Care practices and psychosocial support provided to assist the well-being of the targeted groups. Monitoring psychological well-being and distress of families, and specially caregivers (usually women).
6. To develop programmes within the social protection area of Cash-for-Health to reduce the risk of poverty through access to health.
7. Develop actions of direct and mobile reproductive, maternal, newborn and child health (RMNCH) service provision.
8. Develop actions of capacity restoration of reproductive, maternal, newborn and child primary health care services.

Medium-term actions

1. Capacities of local authorities increased through technical support to better cope with the management and delivery of the basic services
 - a. To improve the capacities of health systems at the level of centres and first level structures in relation to the management of health/nutrition inputs and their supply.
 - b. Supporting systems in continuing HR training in nutrition and maternal and child health.
 - c. To improve the capacities of services provision reduced including water, sanitation in rural, remote and vulnerable communities
2. Capacities and coordination of regional animal, human and environmental health services are strengthened utilising the one-health approaches (South Caucasus only)
3. Behaviour change approach strengthened for an increased collective awareness towards the impact of the disease

1. Continue distribution of material in the community for protection against COVID-19 and other respiratory diseases.
2. Household and community capacities are strengthened to protect those most at risk of suffering serious consequences through a tailored Shielding approach
3. To develop the community intervention package for both diagnosis/prevention and treatment of malnutrition together with the most prevalent childhood diseases.
4. Increase the spaces for community participation in monitoring the quality of services related to nutrition and health, water and sanitation.
5. Continue with the awareness actions related to the prevention and protection against COVID-19 and other respiratory diseases.
6. Facilitating information about available social support and humanitarian assistance services, including remote support and communication.
7. Supporting the referral system and mechanisms.

1. Mapping of data/information available, data systematization, regular monitoring of cost of living (access to food, essential services...) and markets, dissemination
2. Sustainability assessment of agricultural systems, promoting access to farming inputs (seeds, productive infrastructures...), technical assistance to small-scale farmers on Integrated Pest Management/soil and water conservation..., implementation of pilot projects to promote agroecology/low-inputs agriculture, advocacy
3. Labour market and value chain analysis, running of Business shuttle and Schools for employment, support to MSME business start-ups, improving coordination and synergies among local actors in charge of social inclusion/employability, referral to psychosocial support services provision
4. Assessment of safety nets programs and social protection policies, coordination with national social protection actors through Cash Working Groups, design of Cash plus pilots, monitoring and dissemination of results
5. Analysis of value chain of tourism sector, detection of most affected groups and initiative to be promoted for early restoration of the services

1. Monitoring of the barriers to assistance of affected population. Monitoring of the abuse from authorities towards certain groups (discrimination, violence)
2. Donors governments support AAH recommendations for the most effective response modalities and programmatic priorities; including flexible, multi-year and multi-sectoral funding (Increased support to livelihood through early recovery activities and technical assistance; Donors include nutrition as a priority in their strategies; Additional support costs (logistics, material of protection) for COVID-19 response are properly covered by donors; Shielding?) Donor governments implement and apply the necessary humanitarian exemptions in order that sanctions and COTER regulations do not inhibit the maintenance and scaling up of the response to COVID-19
3. Monitoring the impact of COVID 19 on the returnees. Push factor
4. Inclusion of gender analysis, with specific focus on COVID-19 impact

DRIVERS TO CHANGE THE SITUATION

Focus on the economic impact of access to basic services (both wash and nut&health) – cost of the services and access to food

Highlight more role of local Partners for the medium-long term engagement. With this we can also leverage more on Governance and technical assistance

It's key to ensure service continuity, now and in the future (meaning that we will keep having some emergency delivery – i.e. water trucking, hygiene items...) and guarantee social protection systems

Consider psychosocial aspects and options to include it as response, along with IYCF and sexual reproductive health

Minimize the existing widespread fear to access health services

Ensure primary health care and community is functioning and preventive care and curative is developed

Understand the social dynamics, identify barriers to leverage on the Behaviour Change approach at the individual, community and institution level, to boost local leadership to support local initiatives to face the crisis

THE STEPS WE WILL TAKE TO DELIVER THOSE OUTCOMES:

RESTORE BASIC HEALTH AND WASH SERVICES BY IMPROVING RESILIENCE CAPABILITIES ENSURING UNIVERSAL ACCESS / COVERAGE AND CONTINUITY

The restoration of basic services is one of the blocks of intervention. These services must be made more resilient to future situations that could destabilise them again. The coverage of services must be sufficient in terms of both number and population served, and will be reinforced, taking into account the cost-benefit aspect. The aim will be to provide quality services that reduce the inequality gap between groups.

| | |
|--|---|
| <p>Restore basic health and wash services by improving the resilience capabilities of the system, ensuring its universal access / coverage</p> | <p>The Outcomes we aim to achieve</p> |
| | <p>1. Building resilience in terms of HR, leadership capacity and consumables/drugs supply</p> |
| | <p>2. Authorities receive technical support for increasing their capacities to cope with management and delivery of the basic services</p> |
| | <p>3. Health facilities receive support (equipment, water availability...)</p> |
| | <p>4. The system strives for reducing the inequities of services provision</p> |
| | <p>5. Supply chains are maintained and timely replenished</p> |
| | <p>6. Basic services are properly running</p> |
| | <p>7. Basic needs assistance is provided through cash assistance ensuring safety and dignity</p> |
| | <p>8. Targeted vulnerable groups receive the service they need in a individualized and continuative manner</p> |
| | <p>9. Behaviours change approach strengthened for an increased collective awareness towards the impact of the disease</p> |
| | <p>10. Feeding and nutritional practices are promoted among the targeted groups</p> |
| | <p>11. Care practices and psychosocial support is offered to leverage on the well-being of the targeted groups</p> |
| <p>12. Capacities of veterinary and health services are strengthened for one-health approaches (South Caucasus only)</p> | |

Short term actions

1. Accompany the coordination mechanisms in the development of nutritional and health surveys and assessments in each country. Supporting digital assessments and surveys.
2. Coordination / participation in Cash & technical Working Groups, support to MEB definition, design and implementation of cash assistance, knowledge building and sharing.
3. Continuous support and evaluation of the quality of service and its capacities in relation to the COVID19 of the first level health structures.
4. Feeding and nutritional practices are promoted among the targeted groups develop actions of IYFC.
5. Care practices and psychosocial support provided to assist the well-being of the targeted groups. Monitoring psychological well-being and distress of families, and specially caregivers (usually women).
6. To develop programmes within the social protection area of Cash-for-Health to reduce the risk of poverty through access to health.
7. Develop actions of direct and mobile reproductive, maternal, new-born and child health (RMNCH) service provision.
8. Develop actions of capacity restoration of reproductive, maternal, new-born and child primary health care services.

Medium-term actions

1. Resilience capacities of local authorities increased through technical support to better cope with the management and delivery of the basic services
 - a. To improve the capacities of health systems at the level of centres and first level structures in relation to the management of health/nutrition inputs and their supply.
 - b. Supporting systems in continuing HR training in nutrition and maternal and child health.
 - c. To improve the capacities of services provision reduced including water, sanitation in rural, remote and vulnerable communities.
2. Capacities and coordination of regional animal, human and environmental health services are strengthened utilising the one-health approaches (South Caucasus only)
3. Behaviour change approach strengthened for an increased collective awareness towards the impact of the disease

THE COMMUNITY TAKES A CLEAR LEADERSHIP ROLE IN RESPONDING TO THE CONSEQUENCES OF COVID19

The community is expressed and recommended as one of the solutions in the response to COVID19. Community activation should be an opportunity to implement action packages at this level that have an impact on the prevention and treatment of malnutrition. Its involvement would result in an improvement in basic services and in the area of social protection, allowing for a more comprehensive solution.

The community takes a clear leadership role in responding to the consequences of COVID-19

1. People, households and communities vulnerable to COVID-19 are supported
2. Community structures activated to support the provision of basic services
3. Spaces created for dialogue to take place between the different actors of change

1. Continue distribution of material in the community for protection against COVID19 and other respiratory diseases.

2. Household and community capacities are strengthened to protect those most at risk of suffering serious consequences through a tailored Shielding approach, supporting community leadership, local initiatives ensuring informed decision making.

3. To develop the community intervention package for both diagnosis/prevention and treatment of malnutrition together with the most prevalent childhood diseases.

4. Increase the spaces for community

participation in monitoring the quality of services related to nutrition and health, water and sanitation.

5. Continue with the awareness actions related to the prevention and protection against COVID19 and other respiratory diseases.

6. Facilitating information about available social support and humanitarian assistance services, including remote support and communication.

7. Supporting the referral system and mechanisms.

VULNERABLE PEOPLE AND GROUPS CAN SUSTAINABLY RECOVER THEIR LIVELIHOODS THROUGH INNOVATION, INCLUSIVENESS AND ADAPTATION TO FUTURE SHOCKS

Restoring people's livelihoods is a priority. This recovery will have to take into account their ability to cope with and adapt to new crises. A key to some of the contexts is to concentrate efforts on innovative methods that provide alternatives for long-lasting populations and avoid discrimination against excluded populations.

Most vulnerable people and groups can sustainably recover their livelihoods focusing on innovation, inclusiveness and adaptation to future shocks

1. Data and information related to households' economy and market are consolidated for guiding long-term economic recovery
2. Local and sustainable agricultural systems are promoted to improve food supply and competitiveness of small-scale farmers
3. Key sectors and value chains that can contribute to consolidate the local economy and create jobs are strengthened
4. Well targeted and designed social safety nets are piloted at small-scale
5. Tourism sector to support and reinforce, it's an equitable sector that affects several population groups

1. Mapping of data/information available, data systematization, regular monitoring of cost of living (access to food, essential services...) and markets, dissemination.

2. Sustainability assessment of agricultural systems, promoting access to farming inputs (seeds, productive infrastructures...), technical assistance to small-scale farmers on Integrated Pest Management/soil and water conservation..., implementation of pilot projects to promote agroecology/low-inputs agriculture, advocacy.

3. Labour market and value chain analysis, running of Business shuttle and Schools for employment, support to MSME business

start-ups, improving coordination and synergies among local actors in charge of social inclusion/employability, referral to psychosocial support services provision.

4. Assessment of safety nets programs and social protection policies, coordination with national social protection actors through Cash Working Groups, design of Cash plus pilots, monitoring and dissemination of results.

5. Analysis of value chain of tourism sector, detection of most affected groups and initiative to be promoted for early restoration of the services.

POLICIES, REGULATIONS AND DONOR STRATEGIES ENSURE SAFE AND DIGNIFIED ASSISTANCE TO THE AFFECTED POPULATION

Only engaging the duty bearers and the decision makers we'll be able to make a sustainable and durable change. Tackling the impact of COVID19 as a global issue and ensuring that most underserved countries are included in the decision-making process will be essential. Initiatives will be based on the evidences we collect from the people we work with in the field.

Policy, regulations and donors' strategies ensure safe and dignified assistance to the affected population

1. Humanitarian Coordination to address barriers emanating from COVID19 measures and contextual humanitarian access security challenges
2. Donor governments support and advocate for an adequate humanitarian response to the impact of COVID19
3. We analysed the impact of COVID19 on returnees
4. We detect potential loss of rights of women and promote and advocate for gender analysis approach across the interventions of the humanitarian actors

Monitoring of the barriers to assistance of affected population. Monitoring of the abuse from authorities towards certain groups (discrimination, violence)

1. Donors governments support AAH recommendations for the most effective response modalities and programmatic priorities; including flexible, multi-year and multi-sectoral funding (Increased support to livelihood through early recovery activities and technical assistance; Donors include nutrition as a priority in their strategies; Additional support costs (logistics, material of protection) for COVID19 response are properly covered by donors; Shielding?).

2. Donor governments implement and apply the necessary humanitarian exemptions in order that sanctions and COTER regulations do not inhibit the maintenance and scaling up of the response to COVID19.

3. Monitoring the impact of COVID 19 on the returnees. Push factor.

4. Inclusion of gender analysis, with specific focus on COVID19 impact.



4. FINANCIAL REQUIREMENTS FOR 2021

Our work plan is for three years (2021-2023), since the consequences of this crisis are structural and will have an impact in the medium/long term.

FOR 2021, WE ESTIMATE THAT WE WILL NEED 37 MILLION EURO TO BE ABLE TO REACH APPROXIMATELY 1.8 MILLION PEOPLE:

IRAQ

Developing an integrated response:

- To prevent human-to-human transmission of COVID19 through the provision of safe water, sanitation, waste management, hygienic conditions, and awareness raising in health-care facilities, schools, and vulnerable communities.
- Supporting affected populations to access basic needs and restore lost or damaged livelihoods.
- To provide mental health and psychosocial support to the affected populations, including frontline health workers responding to COVID19.

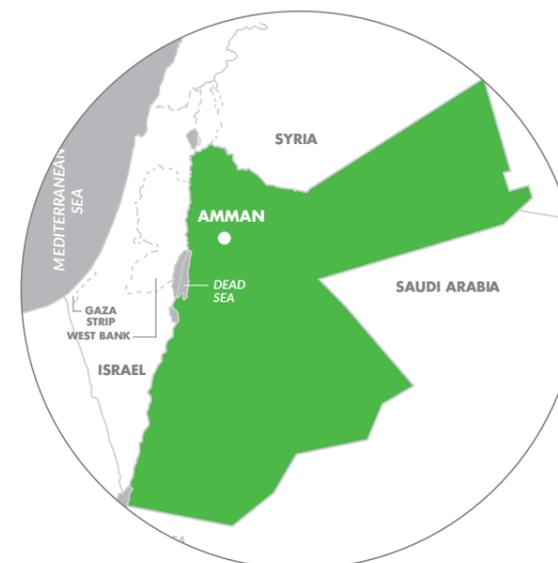
71,084 PEOPLE – 3.11 M EUROS



JORDAN

- Improving water and sanitation infrastructure in Azraq refugee camp to reduce the risk of community transmission of COVID19 and ensure that vulnerable Syrian refugees can self-isolate.
- Reducing community transmission of COVID19 through implementing Risk Communication and Community Engagement (RCCE) strategies to identify and inform people of key transmission risks.
- Providing cash assistance to vulnerable households to ensure they can meet their basic need.
- Providing COVID19 secure Mental Health and Psychosocial (MHPSS) support to vulnerable people. People suffering psychosocial trauma will have access to remote MHPSS services provided by Action Against Hunger's team of psychologists.

101,475 PEOPLE – 1.45 M EUROS

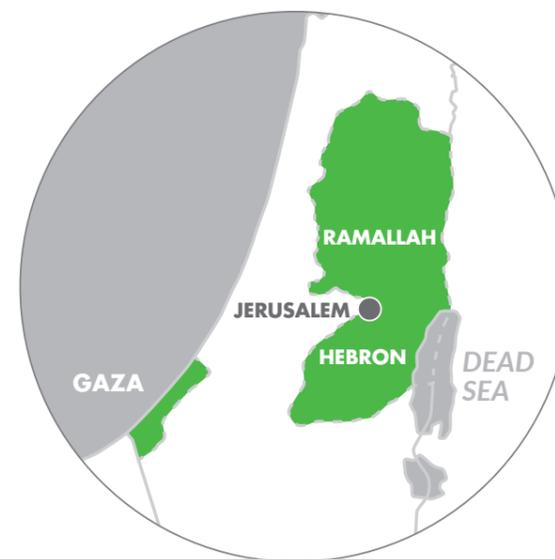




LEBANON

- Syrian refugees in West Bekaa and Aarsal
- Syrian refugees living in ITSs and in Collective Shelters in the South
- Beirut blast affected population in Beirut
- Vulnerable Households and households with pregnant and/or lactating women

66,500 PEOPLE - 4.5 M EUROS



oPT

- Vulnerable households whose situation is aggravated by the movement restriction measures and/or loss of a family member and/or the economic impact of the pandemic
- Vulnerable isolated communities such as communities in remote areas (Area C, under civil and military control of Israel) and in overcrowded urban areas (Gaza Strip)
- Families with people with disabilities (PWDs) with limited households' capacities and resources to mitigate the impacts of the COVID19 outbreak
- Key public institutions - such as village/local councils, quarantine centres etc.- with limited capacities to mitigate the impact of the outbreak and fulfil their obligations to protect the population

38,500 PEOPLE - 2.5 M EUROS



LIBYA



Urban and peri-urban areas of Tripoli and Benghazi through:

- Supporting health facilities to manage COVID19 through training and the provision of supplies.
- Using Risk Communication and Community Engagement (RCCE) strategies to reduce the risk of community transmission of COVID19.
- Strengthening the capacities of community members and frontline workers to face the psychological and psychosocial distress related to COVID19.
- Distribution of hygiene kits to vulnerable households.

44,324 PEOPLE – 1.9 M EUROS

SYRIA



• Isolation Centres, Public Health Facilities and Mobile Clinics

• Vulnerable households; Pregnant and/or Lactating Women, People with Disabilities, People with Special Needs, Children (0-59 months)

• Internal Displaced People in camps, shelters and host communities

• Primary and Secondary Schools

• Technical Ministries and their branches at governorate level

1,250,000 PEOPLE - 18 M EUROS



SOUTH CAUCASUS



- Internally Displaced Persons in Georgia, Armenia, and Azerbaijan
- Returnees to Abkhazia
- Vulnerable persons and groups (ethnic/religious minorities, rural/remote communities, the unemployed, and people with disabilities) in all three countries
- Regional human, animal and environmental health practitioners and agencies
- Schools, collective centres, health points with inadequate water and sanitation facilities that could be potential points of transmission

25,000 PEOPLE – 2M EUROS

YEMEN



- Continuing life-saving and essential health and nutrition services across Yemen during the COVID19 outbreak in line with Action Against Hunger's adaptive protocols and SOPs for COVID19.
- Ensuring Personal Protective Equipment (PPE) for frontline health workers.
- Ensuring triage and screening areas at health facilities to reduce the risk of cross-transmission.
- Strengthening community-based follow up and increasing Risk Communication and Community Engagement (RCCE) strategies.
- Ensuring access to safe drinking water through the rehabilitation of drinking water sources.
- Distribution of hygiene kits to vulnerable households.

250,000 PEOPLE – 3.37 M EUROS





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